CONFIDENTIAL HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name _____ Date: _____

CURRENT COMPLAINTS:
□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain
□ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other: _____

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain:_____
_____
_____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer –Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

FAMILY MEDICAL HISTORY:

Mother: Age: _____ ( ) Living ( ) Deceased
Father: Age: _____ ( ) Living ( ) Deceased
Siblings: Age: _____ ( ) Living ( ) Deceased

Please check each box with if any family member (mother, father or siblings) has had any of the following:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer –Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

CURRENT MEDICATIONS: Please list all current medications below or provide us with a list of medications

Name of Medicine	Strength	Dosage

List of known ALLERGIES: _____
_____

( ) Tobacco ( ) Type: _____ ( ) Alcohol Type: _____
( ) Year begun: _____ How often: _____
( ) Still smoking How much: _____
( ) Year quit: _____ How many years: _____
( ) Packs per day: _____

( ) Exercise ( ) None ( ) light ( ) Moderate ( ) Heavy

Other:_____
_____
_____
_____

REVIEW OF SYSTEMS: Do you have (had) the following?:
Check the appropriate box(s)

GENERAL:	□ Weight gain	□ Weight loss	□ Fever	□ Hair loss
	□ Weakness	□ Other: _____		
EYES:	□ Eye strain	□ Wear glasses or contact lenses		□ Sensitivity to light
EAR, NOSE,THROAT	□ Ringing in ears	□ Hearing loss	□ Discharge or pain	□ Dizziness
	□ Runny nose	□ Difficulty breathing through nose		□ Sinusitis
	□ Painful teeth, gums, or palate		□ Growths in the mouth	
	□ Pain or difficulty swallowing		□ Hoarseness	
CARDIOVASCULAR	□ Palpitations	□ Chest pain	□ Fainting	□ Dizziness
	□ Varicose veins	□ Difficulty climbing Stairs		□ Pain in the legs
	□ Cold Feet/Hands		□ Shortness of breath	
RESPIRATORY	□ Shortness of breath while walking		□ Cough with or without phlegm	
	□ Asthma/Wheezing		□ Spit up blood	
	□ Other: _____			
GASTROINTESTINAL	□ Abdominal pain	□ Nausea	□ Vomiting	□ Diarrhea
	□ Hemorrhoids	□ Change in shape or color of stool		
GENITOURINARY	□ Discharge	□ Pain	□ Frequent urination	□ Pain with urination
MUSCULOSKELETAL	□ Weakness	□ Back Pain	□ Neck Pain	□ Leg Pain
	□ Arm Pain	□ Shoulder Pain	□ Numbness	□ Headaches
	□ Other: _____			
SKIN	□ Jaundice	□ Dry skin	□ Pigment Change	□ Growths
	□ Moles that have changed color, shape, or bleed			
NEUROLOGIC	□Tremors	□ Weakness	□ Numbness	□ Memory Loss
	□ Confusion	□ Other: _____		